Laboratory Fraud and Abuse

Why look at Clinical Laboratory Services:

- Medicare covers 100% of the charges, so beneficiaries pay less attention to these bills than those with a co-pay.

- Physicians do not see what the laboratories bill to Medicare.

- Medicare has not required laboratories to submit diagnosis or symptom information to support the need for most lab tests.

- Once a fraudulent laboratory obtains Medicare information, that lab may sell Medicare Health Insurance Claim Numbers to other fraudulent laboratories.

Fraud Schemes:

- **ROLLING LABS –** laboratories on wheels that go to senior centers, shopping malls, etc. offering **"free"** diagnostic tests. Patients are required to complete a registration form that includes their Medicare Health Insurance Claim Number. The lab may perform some simple tests and bill Medicare for a series of complex and expensive tests. Sometimes Medicare is billed for a variety of tests that were never even performed.

  Are all "rolling labs" fraudulent? NO! The red flag here is when these labs misrepresent the services they provide as "free," and then bill Medicare.

- Laboratories have added tests not ordered by the physicians and billed them separately to Medicare.

- **UNBUNDLING**. – billing laboratory tests separately to charge a higher amount than if they are combined and billed as one service. Labs market their tests as panels to physicians, but split certain tests off the panels and bill them separately to Medicare.

- **For example**, three national medical laboratories defrauded federal and state governments by billing them for basically worthless and unnecessary tests. Damon, a subsidiary of Corning, Inc. agreed to pay $119 million in criminal and civil fines to settle a case involving two whistleblower lawsuits and criminal charges that the company had submitted false claims to Medicare and Medicaid programs in 27 states including Arkansas for laboratory tests that were not ordered and were not medically necessary.[1] In addition, whenever a doctor ordered a standard blood test, known as a "complete blood count" (CBC), Damon billed Medicare and Medicaid for additional evaluations known as CBC indices. The government also charged that Damon routinely tacked on unnecessary tests when doctors ordered serial multi-channel automated chemistry (SMAC) tests and billed Medicare and Medicaid separately for them.

  "The national medical laboratories have been draining hundreds of millions of dollars from the Medicare program and federal treasury by billing the government for tests that doctors didn't want and patients didn't need."[1] The lawsuits were filed under the False Claims Act, which allows individuals (whistleblowers) to sue companies that submit false claims to the federal government. The government is entitled to as much as three times the damages. The False Claims Act encourages private citizens to report fraud by rewarding them with 15-30% of whatever money the government recovers.

  "Whistleblower lawsuits have sparked federal investigations that have helped clean-up the medical lab industry and strengthen the Medicare program...Those lawsuits have proven how effective the False Claims Act can be in helping the government fight fraud."[1]

- Laboratories have billed for services not ordered or provided.

  For example, one lab submitted 717 claims to Medicare in a single 6-day period on behalf of 416 beneficiaries (**many of whom were already dead**), and received $330,000. One of the "referring" physician listed on the claims had been dead for 2 years. In a random sample, nearly a third of the beneficiaries had never received

[1] *"Corning to pay $119 million to settle a case of Medicare billing by Damon,"* The Wall Street Journal (10/10/96).

services from the lab or did not know the referring physician listed on their claims.

What is an Independent Physiological Laboratory (IPL)?

IPLs are free standing facilities (not part of a doctor's office or other health care facility) that perform non-invasive diagnostic tests, such as x-rays, magnetic resonance imaging (MRI), oxygen tests (pulse oximetry), etc.

Why look at IPLs?

- There is huge potential for quick profit.
- There are no professional licensing requirements. All that's needed in order to obtain a provider number is a standard business license.
- In the past, Medicare contractors have not verified the existence of the laboratory or the lab equipment required to perform the tests that are billed to Medicare.
- IPLs have found it relatively easy to obtain beneficiaries' Medicare Health Insurance Claim Numbers.

IPL Fraud Schemes:

- Many IPLs have falsified results of various oxygen tests that are performed to substantiate the patient's need for oxygen.

  ✓ One test that is required is an O_2 saturation level taken while resting. Several IPLs have been found to have offices located up one or two flights of stairs, thus requiring the patient to climb the stairs right before this test is performed.

  ✓ Many IPLs have been found to have financial ties to oxygen suppliers.

✓ Some durable medical equipment (DME) suppliers have ownership in or arrangements with physiological laboratories that falsify oximetry tests[2] to certify a patient's need for home oxygen.

- Some IPLs perform sleep studies without a physician's order. They falsify the Certificate of Medical Necessity (CMN) signed by the ordering physician in order to receive payment from Medicare.

- Some IPLs have advertised "stroke prevention" testing. They perform a series of diagnostic tests, all or most of which are not medically necessary and/or proven effective.

- Falsification of claims or duplicate billing:

For example, one IPL sent nurses to the homes of patients who required cardiac monitoring using an "event recorder." The equipment was hooked up for approximately 20 to 30 minutes, then removed and taken with the nurse. This provider billed Medicare for 24-hour attended monitoring for these patients. In addition, the lab billed the same claims for numerous patients to two separate Medicare carriers in an attempt to receive duplicate payment.

For example, one national IPL billed Medicare for over $5.9 million for Magnetic Resonance Imaging (MRI) services that were not provided. The provider used several different business names, none of which were legitimate businesses. The business addresses provided on their applications were merely mail drops.

Things to look for:

- Advertisements for **"free"** diagnostic tests, including sleep studies, stroke prevention studies, oxygen tests, etc. that are later billed to Medicare or other insurers. **NOTE WELL: All diagnostic tests must be ordered by the patient's personal physician.** For this reason, the dates of service on laboratory claims should generally be within 7-10 days of your doctor's visit.

[2] Pulse oximetry is a simple non-invasive method of monitoring the percentage of hemoglobin (Hb) that is saturated with oxygen.

- Review Explanation of Medicare Benefits (EOMB) or Medicare Summary Notice (MSN) to ensure that the laboratory tests billed match those that were provided. Make sure the following are correct and were provided:

  ✓ The date of service,

  ✓ The name of the doctor who prescribed the service, and

  ✓ The tests performed.

- Did the IPL waive co-pays and deductibles in the absence of financial need?

It is in your best interest and that of all citizens to report suspected fraud. Health care fraud, whether against Medicare, Medicaid or private insurers, increases everyone's health care costs, much the same as shoplifting increases the costs of the food we eat and the clothes we wear. If we are to maintain and sustain our current health care system, we must work together to reduce costs.

To Report Suspected Medicare or Medicaid Fraud
Call Toll-free 1-800-726-2916
Or Write to Address Below